May 5, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-03-0848-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the ___ external review panel. This physician is board certified in anesthesiology. The ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 29 year-old male who sustained a work related injury on ___. The patient reported that while at work he injured his back when he bent over to pick up some bent hoses. The diagnoses for this patient include lumbar disc protrusions with annular tears as per MRI, bilateral lumbar facet syndrome, lumbar radiculopathy and myofascial syndrome. The patient has been treated with physical therapy, chiropractic care, oral pain medications, and epidural steroid injections.

Requested Services

Lumbar Discogram with Post CT Scan at L3-4, L4-5 and L5-S1.

Decision

The Carrier's denial of authorization for the requested services is upheld.

Rationale/Basis for Decision

The ___ physician reviewer noted that the patient sustained a work-related injury on ___. The ___ physician reviewer also noted that the patient underwent an MRI 5/8/01 that demonstrated spine curvature, L3-4 disc protrusion, L4-5 degenerative disc disease and disc protrusion with posterior left annular tear, and L5-S1 disc space narrowing, degenerative disc disease and disc protrusion. The ___ physician reviewer further noted that the patient has undergone conservative treatment with physical therapy, chiropractic care, and oral pain medications. The ___ physician reviewer indicated that the patient has also been evaluated by a pain management specialist and has undergone epidural steroid injections, lumbar facet joint injections, and radiofrequency ablation of the lumbar facet joints. The ___ physician reviewer explained that the patient continues to complain of low back pain.

The ___ physician reviewer also explained that the patient is being maintained on Lortab, Soma, Naprosyn, and Ambien for pain control. The ___ physician reviewer noted that the patient has been evaluated by a pain management specialist and has been diagnosed with bilateral lumbar facet syndrome, lumbar radiculopathy and myofascial pain syndrome. The ___ physician reviewer explained that the patient has failed to respond to conservative and interventional therapies and continues to require significant analgesics for pain control. The ___ physician reviewer indicated that there is no evidence that the patient has received evaluation regarding surgical intervention. The ___ physician reviewer explained that the requested discogram is not medically necessary because it will not likely add information regarding his need for a surgical procedure. Therefore, the ___ physician consultant concluded that the requested lumbar discogram with post CT scan at L3-4, L4-5 and L5-S1 is not medically necessary to treat this patient's condition at this time.

This decision is deemed to be a TWCC Decision and Order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 (ten) days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within 20 (twenty) days of your receipt of this decision. (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed. (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

A copy of this decision should be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute. (Commission Rule 133.308(t)(2)).

Sincerely,

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 6th day of May 2003.